

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/01/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00130367.</p> <p>This visit was in conjunction with a post survey revisit (PSR) to complaints IN00125084, IN00125768 and IN00129216 investigated on May 28, 2013.</p> <p>Complaint IN00130367-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: July 1, 2013</p> <p>Facility number: 00098 Provider number: 155187 AIM number: 100290980</p> <p>Survey team: Janelyn Kulik, RN, TC Yolanda Love, RN</p> <p>Census bed type: SNF/NF: 149 Total: 149</p> <p>Census payor type: Medicare: 20 Medicaid: 116 Other: 13 Total: 149</p> <p>Sample: 10</p> <p>Golden Living Center-Fountainview Place, Portage was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/01/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 IN00130367. Quality review completed on July 3, 2013, by Janelyn Kulik, RN.	F 000			